DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445071	A. BUILDING _____ B. WING _____	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE COUNTY NURSING HOME	1850 OLD KNOXVILLE ROAD TAZEWELL, TN 37879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS AMENDED: October 22, 2012. An annual recertification survey and complaint investigation #29354 were completed at Claiborne County Nursing Home on October 10, 2012. No deficiencies were cited related to complaint investigation #29354 under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278	F278 Resident # 8, identified in this deficient practice will have her Quarterly Minimum Data Set updated to reflect accurately her number of falls, by the MDS Coordinator at the next scheduled update. Responsible Person: MDS Coordinator Completion Date: 11/27/2012. All other Residents utilizing low beds are being reviewed to identify any reported "roll outs" not included as falls on their Quarterly Minimum Data Sets. Any identified deficiencies will have accurate number of "roll outs" classified as falls on their next scheduled Quarterly MDS. Responsible Person: MDS Coordinator	11/27/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tim S Brown	Administrator	10/26/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 278	Continued From page 1 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigation, and interview, the facility failed to accurately document the number of falls on the Quarterly Minimum Data Set for one resident (#8) of eighteen residents reviewed. The findings included: Resident #8 was admitted to the facility on May 11, 2011, and readmitted to the facility on May 29, 2012, with diagnoses including Gastrostomy, Failure to thrive, Congestive Heart Failure, Hypoxemia, Rheumatoid Arthritis, Vascular Dementia, and Psychosis. Review of facility investigations revealed the resident had falls on June 12, 2012; June 15, 2012; July 4, 2012; July 18, 2012; July 20, 2012; July 29, 2012; August 14, 2012 and August 31, 2012, for a total of eight (8) falls between June 12, 2012 and August 31, 2012. Review of a Quarterly Minimum Data Set (MDS) dated September 4, 2012, revealed documentation the resident had one fall with injury since prior MDS Initial Assessment dated June 11, 2012. Interview on October 9, 2012, at 3:00 p.m., in the Dining Room, with the MDS Coordinator, confirmed the Quarterly MDS did not accurately document the number of falls the resident had	F 278	The MDS and PPS coordinators have been educated to include "roll out of low beds" as a fall, using the state definition of a fall being any unplanned change of plane. They were also instructed to accurately report these on Quarterly MDS profiles. Responsible Person: Director of Nursing All event reports will be reviewed by Director of Nurses or his designee and the MDS Coordinator to ensure that "roll outs of low beds" are reported on MDS as falls. # of "low bed roll outs" reported per Resident + # of falls reported per Resident = the total # of falls documented on Quarterly MDS updates. This data will be collected and aggregated by the MDS Coordinator and reported to the Director of Nursing and Administrator on a monthly basis. Responsible Person: MDS Coordinator	

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F 278	Continued From page 2 experienced since the prior MDS.	F 278		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to label and date tube feeding solution for one resident (#5) of eighteen residents reviewed. The findings included: Resident #5 was admitted to the facility on July 15, 2009, and readmitted to the facility on June 6, 2012, with diagnoses including Chronic Kidney Disease, Uncontrolled Diabetes, Dementia, Psychosis, Peripheral Vascular Disease, Gastrostomy, and Stage 4 Pressure Ulcer. Observation of the resident on October 8, 2012, at 1:00 p.m., 2:00 p.m., 3:45 p.m., and 4:30 p.m., revealed the resident receiving continuous tube feeding solution at 66 ml (milliliters) per hour via pump and gastrostomy tube (a tube surgically placed into the stomach through the abdominal wall). Continued observation revealed the solution was contained in a 1200 ml opaque plastic container with the manufacturer's label	F 322	F322 Resident # 5 identified in this deficient practice immediately had the date and time added to his enteral feeding container, by the LPN providing resident care. Responsible Person: Director of Nursing The licensed staff member identified as involved in the deficient practice was reeducated by the Director of Nurses on the importance of compliance with facility policies and procedures regarding labeling and dating of enteral feedings. 100% of Residents receiving enteral feedings have been reviewed to ensure feeding container is correctly labeled and dated. Responsible Person: Director of Nursing 100% of the licensed nursing staff will be educated on the importance of compliance with facility policy and procedure with emphasis on labeling and dating enteral feeding containers. Attendance of education session will be verified by	11/16/12

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F 322	Continued From page 3 affixed and no date or time of administration was noted on the container or the line from the container to the resident. Interview with LPN #2 on October 8, 2012, at 4:35 p.m. at the 200 hall nursing station, revealed the administration of the solution began on October 7, 2012, at 10:00 p.m., and confirmed the facility had failed to ensure the time and date of administration was on the label.	F 322	F322 continued participants signature on the "sign-in" sheet. Responsible Person: Director of Nurses Compliance rate will be determined by the # of Residents enteral feeding containers that are labeled and dated / total # of residents with enteral feedings = rate of compliance. Expected compliance is expected to be 100%. Daily walk through rounds by Charge Nurses will be used to collect compliance data. The Charge Nurses will submit the data to the Director of Nurses. The Director of Nurses will aggregate the data and report compliance rate to the Administrator and Medical Director for three months of sustained compliance. This data will then be reported to the Quality Management Committee. Responsible Person: Director of Nurses	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility investigation, and interview, the facility failed to ensure proper use of safety devices for two residents (#8, #13), failed to properly ensure the safety of one resident (#8) during transfer using a Hoyer lift, failed to document and ensure implementation of new interventions to prevent future falls for one resident (#8), and failed to transfer one resident (#12) per care plan, of eighteen residents reviewed. The findings included:	F 323		

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F 323	Continued From page 4 Resident #8 was admitted to the facility on May 11, 2011, and readmitted to the facility on May 29, 2012, with diagnoses including Gastrostomy, Failure to Thrive, Congestive Heart Failure, Hypoxemia, Rheumatoid Arthritis, Vascular Dementia, and Psychosis. Review of the Quarterly Minimum Data Set (MDS) dated September 12, 2012, revealed the resident had severely impaired cognition and required extensive assistance with activities of daily living (ADLs). Observation of the resident's room on October 8, 2012, at 2:15 p.m., revealed alarms and motion sensors to each side of the resident's bed and fall mats to both sides of the resident's bed. Observation of the resident on October 8, 2012, at 2:30 p.m., outside the second floor nurse's station, revealed the resident sitting in a rocking wheelchair with sensor alarms to each side of the wheelchair and a wanderguard bracelet attached to the resident's right ankle. Review of facility investigations dated October 1, 2011, October 29, 2011, Novmber 2, 2011, November 14, 2011, December 29, 2011, and March 3, 2011, revealed the resident had falls without injury. Continued review revealed interventions of "...continue low bed, alarm...respond to alarms quickly...Make sure bed alarm pad laying horizontal...continue low bed and alarms...continue low bed with fall mats bilaterally...continue to keep fall mats at bedside and respond to alarms, continue low bed.." Review of a facility investigation dated April 5,	F 323	**F323** Employee that was involved in the deficient practice involving Resident # 8 on 04/08/2012 was counseled about the importance of making sure alarms are applied and operating properly. No further occurrences involved this employee. Responsible Person: Director of Nurses Employee that was involved in the deficient practice involving Resident # 8 on 07/29/2012 was counseled about the importance of making sure alarms are applied and working properly. No further occurrences involved this employee. Responsible Person: Director of Nurses Employee that was involved in the deficient practice involving Resident # 8 on 09/19/2012 was counseled about the importance of following the Resident's plan of care for the safety of the	11/16/12

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F 323	Continued From page 5 2012, revealed the resident while seated in a wheelchair in front of the second floor nurse's station, flipped the wheelchair over without injury. Continued review of the facility investigation revealed alarm on wheelchair "...was not turned on..." Review of facility investigations dated June 2, 2012, June 12, 2012, June15, 2012, July 4, 2012, July 18, 2012, and July 20, 2012, revealed the resident had falls without injury. Review of the facility investigations revealed interventions of "...alarm on resident at all times, instructed daughter...Place bolsters on sides of bed...monitor frequently, maintain alarms, PT (physical therapy) screen...continue use of low beds and alarms...monitor resident frequently when restless behavior...continue low bed and respond to alarms as quick as possible..." Continued review revealed no new interventions implemented to prevent further falls on on July 4, 2012, or July 20, 2012. Review of a facility investigation dated July 29, 2012, revealed the resident had a fall on in the resident's room resulting in no injury to the resident. Continued review of the facility investigation revealed safety alarms were not sounding, mobile alarms did not detach from the resident, and "...motion sensor turned off...AC adaptor not plugged into alarm..." Review of facility investigations dated August 14, 2012 and August 31, 2012, revealed the resident had falls without injury. Continued review revealed no new interventions were implemented to prevent further falls after the August 14, 2012, fall. Continued review revealed interventions of	F 323	Resident and employees. No further occurrences involved this employee. Responsible Person: Director of Nurses Employee that was involved in the deficient practice involving Resident # 13 on 04/17/2012 was counseled about the importance of making sure the Resident alarm is applied and operating properly. No further occurrences involved this employee. Responsible Person: Director of Nurses Employee that was involved in the deficient practice with Resident # 12 on 06/11/2012 was counseled about the importance of following the Residents care plan for the safety of Resident and employee. No further occurrences involved this employee. Responsible Person: Director of Nurses	

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F 323	Continued From page 6 "...monitor frequently when up in w/c (wheelchair) and reposition resident back in w/c when needed, OT (occupational therapy) to screen..." Review of a facility investigation dated September 19, 2012, revealed the resident was dropped without injury during a transfer to bed by one staff person using a Hoyer lift (device used to transfer residents who cannot safely transfer themselves). Further review of the facility investigation revealed, "...should have x2 (times two) staff with transfers with lift..." Medical record review of the Care Plan updated on September 20, 2012, revealed, "...Only 1 CNA (Certified Nurse Assistant) was present at time of fall. 2 CNA (s) are supposed to be present during TF (transfer) with lift..." Interview on October 9, 2012, at 2:46 p.m., with the Director of Nursing (DON), in the DON's office, confirmed the safety devices in place at the time of the resident's falls on April 5, 2012, and July 29, 2012, were not functioning properly. Continued interview with the DON confirmed two staff members were required to be present while transferring the resident with a Hoyer lift and the resident's care plan was not followed resulting in a fall on September 19, 2012. Further interview with the DON confirmed no new interventions were implemented after falls on November 14, 2011, December, 29, 2011, and March 31, 2012. Continued interview confirmed "were not aware of other interventions (to be attempted" on additional falls which occurred on July 4, 2012,	F 323	With physician order, we have removed Resident #8 bilateral ½ length bed rails, as a new intervention to help decrease the number of repeated "roll outs" of low beds. All other furniture has been moved from area of "roll-outs" to prevent injury. Responsible Person: Director of Nurses 100% of the Nursing Home direct patient care staff will be educated on the importance of compliance with facility policies and procedures and individual Resident's care plan, for the safety of the Resident and the staff. Emphasis to be made on correct application of safety monitors and validation of their functionality. Emphasis will also be made on the necessity and importance of compliance with individual Resident's care plans. Attendance of education session will be verified by participants signature on the "sign-in" sheet. Responsible Person: Director of Nurses	

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F 323	Continued From page 7 July 20, 2012, and August 14, 2012. Resident #13 was admitted to the facility on September 11, 2010, with diagnoses including Cerebrovascular Accident, Altered Mental Status, Old Myocardial Infarction and Parkinson's Disease. Observation of the resident in the resident's room, on October 10, 2012, at 9:46 a.m., revealed the resident lying in bed with a full padded side rail up on the right side of the bed. Continued observation revealed an alarm hanging from the side rail of the bed. Review of a facility investigation dated April 17, 2012, revealed "...found R (resident) on BR (bedroom) SOB (side of bed)...alarm attached to R and bed still..." Further review revealed, "...make sure mobile alarm is attached to bedrail where will not slide with resident..." Interview on October 10, 2012, at 10:20 a.m., with the DON, in the DON's office, confirmed the facility had failed to ensure the safety alarms were applied correctly to alert staff of unassisted transfers. Resident #12 was admitted to the facility on January 12, 2012, with diagnoses of Renal Dialysis, Chronic Kidney Disease, Malaise and Fatigue, and Diabetes Mellitus Type II. Medical record review of the Care Plan revealed the resident fell on May 2, 2012, with no injury, and the Care Plan had been updated to include interventions to prevent falls including "...assist of two for transfers..."	F 323	Compliance rate will be determined by monitoring the # of Residents that have alarms that are attached and operating properly / total # of Residents with alarms in use = rate of compliance. Expected compliance is expected to be 100%. Daily walk through rounds by licensed staff will be used to gather compliance data in conjunction with daily monitoring of each event report. The licensed staff will provide the data to the Director of Nurses. The Director of Nurses will aggregate the data and report the compliance rate to the Administrator and Medical Director on a monthly basis. Monitoring will continue until compliance rate of 100% is obtained and maintained for at least 3 consecutive months. Responsible Person: Director of Nurses	

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F 323	Continued From page 8 Continued medical record review of the Care Plan revealed the resident fell again on June 11, 2012, and was updated to include "...Resident was lowered to floor during transfer with assist x1. Resident needs assist x2 for safe transfers..." Review of a facility investigation dated June 11, 2012, revealed "...transfer with assist of one with fall,..care plan called for assist of two...educate CNA (Certified Nursing Assistant) on following care plan for assist of two on transfers...PT (Physical Therapy) to evaluate..." Interview with the Assistant Director of Nursing (ADON), in the DON's office, on October 10, 2012, at 10:20 a.m., confirmed the resident's fall on June 11, 2012, was the result of the CNA not following the care plan.	F 323	**Bullet # 2 of POC For F323** **100% of residents with alarm devices and side rails were checked by Charge nurses for functioning alarms and proper placement 10/11/2012. 100% of devices checked were found to be properly attached and with functioning alarm. Only the one bedrail of Resident # 8 required intervention. Daily assessments made by licensed personnel. Responsible Person: Director of Nurses**	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		

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F 323	Continued From page 8 Continued medical record review of the Care Plan revealed the resident fell again on June 11, 2012, and was updated to include "...Resident was lowered to floor during transfer with assist x1. Resident needs assist x2 for safe transfers..." Review of a facility investigation dated June 11, 2012, revealed "...transfer with assist of one with fall...care plan called for assist of two...educate CNA (Certified Nursing Assistant) on following care plan for assist of two on transfers...PT (Physical Therapy) to evaluate..." Interview with the Assistant Director of Nursing (ADON), in the DON's office, on October 10, 2012, at 10:20 a.m., confirmed the resident's fall on June 11, 2012, was the result of the CNA not following the care plan.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	F441 Immediately after the nurse became aware of the identified deficient practice involving Resident # 3, the undated nebulizer mask was removed and replaced with a new mask with date placed on the mask. 100% of Residents with orders for nebulizer masks/treatments were checked to make sure masks were clean and dated. Responsible Person: Director of Nurses	11/16/12

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F 441	Continued From page 9 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to provide a sanitary, labeled, nebulizer facemask for one resident (#3), of eighteen residents reviewed. The findings included: Resident #8 was admitted to the facility on July 31, 2008, with diagnoses of Gastrostomy Status, Dysphagia, Paralysis Agitans, Hematemesis, Senile Dementia, Gastroduodenal Disease, and Malaise and Fatigue. Observation of the resident during the initial tour on October 8, 2012, at 10:50 a.m., revealed the	F 441	100% of the licensed nursing staff will be educated on the importance of compliance with facility policies and procedures, focusing on scheduled changing and dating nebulizer masks on a weekly and PRN basis. Attendance of education session will be verified by participant signature on the "sign-in" sheet. Responsible Person: Director of Nurses Compliance rate will be determined by the # of Resident's that have nebulizer masks that are dated and clean / Total # of Residents with orders for nebulizer masks or treatments = rate of compliance. Expected compliance is to be 100%. Daily walk through rounds by the charge nurses will be used to gather compliance data. The charge nurses will provide the data to the Director of Nurses who will aggregate and trend it. The Director of Nurses will then report the compliance data to the Administrator and Medical	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445071	A. BUILDING _____ B. WING _____	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE COUNTY NURSING HOME	1860 OLD KNOXVILLE ROAD TAZEWELL, TN 37879

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F 441	Continued From page 10 respiratory nebulizer face mask in a clear plastic bag was undated, without the resident's name, and had a buildup of a yellow substance inside the mask. Review of facility policy, Oxygen Therapy, revised October 2008, revealed "...Change handheld nebulizer setups weekly. Keep setup in plastic bag when not in use, labeled with residents name and date..." Interview with Licensed Practical Nurse (LPN) #1 in the residents' room on October 8, 2012, at 10:53 a.m., confirmed the nebulizer mask had a buildup of a yellow colored substance and did not have a date or name written on it. Continued interview confirmed LPN #1 could not provide documentation of when the nebulizer mask had been changed.	F 441	F 441 cont. Director monthly for at least three months or until sustained compliance is achieved for three consecutive months. The Director of Nurses will report this data to the Quality management Committee bimonthly at scheduled meetings.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced	F 514	**F514** Immediately after staff became aware of the deficient practice identified involving Resident # 13, the physician recapitulation orders were placed on the chart. Responsible Person: Director of Nurses Completion Date: 10/10/2012 100% of Resident medical records were reviewed to make sure that physician recapitulation orders were on chart and current. Responsible Person: Director of Nurses Completion Date: 10/12/2012	11/16/12

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F 514	Continued From page 11 by: Based on medical record review and interview, the facility failed to maintain a current and readily accessible clinical record for one resident (#13) of eighteen residents reviewed. The findings included: Resident #13 was admitted to the facility on September 11, 2010, with diagnoses including Cerebrovascular Accident, Altered Mental Status, Old Myocardial Infarction and Parkinson's Disease. Medical record review of Physician Recapitulation Orders revealed the Physician Recapitulation Orders were last signed and dated by the Physician on July 27, 2012, and "...No order may stand for more than 60 days..." Continued medical record review revealed no additional Physician Recapitulation orders in the medical record after July 27, 2012. Interview on October 10, 2012, at 9:10 a.m., with the Director of Nursing (DON) in the DON's office, confirmed Physician Recapitulation Orders were not current and not in the resident's chart.	F 514	100% of physician recapitulation orders will now be completed every 30 days, with Resident charts divided relative to room/floor assignment. This division will promote continuity and eliminate the possibility of oversight. 100% of licensed nursing staff will be educated on this revised process and the importance of maintaining this rotating schedule. Attendance of this education session will be validated by employee signatures on the "sign-in" sheet. Responsible Person: Director of Nurses 100% chart review will be conducted by Director of Nurses designee(s) monthly by the date recapitulation is scheduled to be completed on each floor. # of charts with completed recapitulation / Total # of Resident charts due recapitulation = % compliance. Expected compliance rate is 100%. The Director of Nursing will aggregate this data and	

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